SAVE PRINT CLEAR

SAN FRANCISCO OFFICE
525 GOLDEN GATE AVENUE
SAN FRANCISCO
MAIL ADDRESS: P. O. BOX 603
SAN FRANCISCO 94101

PLEASE SEND TWO COPIES

STATE OF CALIFORNIA
Department of Industrial Relations
Division of Industrial Accidents
DISABILITY EVALUATION BUREAU

LOS ANGELES OFFICE
LOS ANGELES STATE OFFICE BUILDING
107 SOUTH BROADWAY
LOS ANGELES 90012

EMPLOYEE'S REQUEST FOR INFORMAL PERMANENT DISABILITY RATING

This form should be completed and submitted as soon as the permanent effects of the injury appear stationary.

IMPORTANT--This is not a request for a Hearing or an Award. This will not prevent the operation of the Statute o Limitations.

EMPLOYEE_____ EMPLOYER_____
(Please Print)

Social Security No._____ Address_____
(Zip Code)

Address_____ Nature of employer's business_____
(Street and Number, or Rural Route)

_____
(City) (Zip Code)

Date of injury_____
(Month) (Day) (Year)

Age (give date of birth)_____ Employer's Workers' Compensation Insurance Carrier:
(Month) (Day) (Year)

Occupation (at time of injury)_____ _____

Have you returned to work?_____Date_____

Have you ever sustained any other permanent disability?___If so, when ?_____

What was its nature?_____

PLEASE ANSWER FOLLOWING QUESTIONS FULLY, using reverse side if needed.

What were the general duties of your job when you were injured?

What is your disability resulting from this injury?

How does this disability affect you in your work?

Sign here_____Date_____